

Regence BlueCross BlueShield of Oregon 100 SW Market Street PO Box 1271 Portland, Oregon 97207-1271

Waiver Form

am waiving coverage for the following reason(s). Check all that apply: I do not wish to enroll myself and/or my dependent(s) in my group's medical plan at this time. I currently have medical coverage elsewhere: Carrier Policy Number Policy Type: Group Individual Medicare Medicaid TriCare Indian Health Service Government sponsored health plan Other I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I currently have dental coverage elsewhere: Carrier Policy Type: Government sponsored health plan Other I do not wish to enroll myself and/or my dependent(s) in my group's dental plan at this time. I currently have dental coverage elsewhere: Carrier Policy Type: Policy Type: Group Individual Member ID Number Policy Type: Group Individual Medicare Medicaid TriCare Indian Health Service Government sponsored health plan Other Yppe: Group Individual Medicaid TriCare Indian Health Service Government sponsored health plan Other If you have checked the above for medical and/or dental coverage elsewhere but did not indicate the Carrier	SECTION 1 - GROUP INFORMATION									
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I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my group's health plan throug Regence until the next annual enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.										
I further certify that all information completed on this form is true, correct and complete and acknowledge that m coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false c incorrect.	coverage is subject to cancellation or other action permissi									
Signature of Employee	Signature of Employee									
Signature of Employee Date						Da				